The many Historical Connections between *Schizophrenia* and *Dissociation: Coincidence - or Evidence for an Unrecognized Relationship?*

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Perspectives on the relation between dissociation and psychosis

1. Historical and current meaning of the terms dissociation and psychosis
2. A role for dissociation in some/all psychotic symptoms
3. Evidence for a mental disorder characterized by an admixture of dissociation and psychosis
   □ ‘Dissociative psychosis’ or ‘Dissociative schizophrenia’
4. The concept of schizophrenia and its relation to dissociation
Could *schizophrenia* be a *dissociative disorder*?

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<th>Ego (Experienced identity)</th>
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<td>integrated</td>
<td>integrated, but with many personality facets</td>
<td>integrated, but with loosening of the cohesion of subselves</td>
<td>multiple personality</td>
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Christian Scharfetter’s (2008) *continuum of dissociation*
But schizophrenia is not DID.

‘I assume that a highly unstable and fluctuating ego-self [in DID] is less disposed to ego-fragmentation – the most severe form of dissociation. It is even possible that the very unstable fluctuating ego-self protects it from fragmentation (i.e., is schizo-preventive). This would mean that the precondition for a schizophrenic dissociative ego-disorder would be a more rigid ego, disposed for fragmentation rather than fluctuation. One can imagine schizophrenia syndromes as glass and dissociative identity disorders as quicksilver: the rigid glass fragments split apart and do not reassemble easily, whereas the quicksilver glides smoothly apart into globes – little wholes – but quickly unites without splitting apart’ (p. 61).

This is a unique view; most do not see the disturbances of self or ego in schizophrenia as dissociative in nature.
Historical enigmas around schizophrenia and dissociation

If schizophrenia is unrelated to dissociation/dissociative disorders, how do we understand these puzzles?

- Bleuler’s schizophrenia and dissociation theory
  - Why was the historical concept of schizophrenia so influenced by the ideas of Pierre Janet and dissociation theory?

- Schneider’s 1st rank symptoms of schizophrenia and dissociative identity disorder (DID)
  - Why were/are the 1st rank symptoms, frequently present in DID, considered highly predictive for schizophrenia?

- Bateson’s double-bind theory of schizophrenia and disorganized attachment (DA)
  - SOME SLIDES NOT INCLUDED
Enigma 1: Eugen Bleuler and the creation of schizophrenia

Bleuler at the Rheinau asylum (1886-1898)
Bleuler, Carl Jung and the birth of schizophrenia (1900-1911)
Dissociation and schizophrenia

In the years prior to 1908, dissociation was emphasized by others seeking alternative terms for Kraepelin’s *Dementia Praecox* (Scharfetter, 2001)

- Wernicke’s *Sejunktionspsychosis*, Zweig’s *Dementia dissecans*, Gross’s *Dementia sejunctiva*
Jung at Burghölzli (1900 - 1909)

- Jung strongly influenced Bleuler’s concept of schizophrenia
- 1902 – completes medical thesis on the possession states of a medium, supervised by Bleuler, *On the Psychology and Pathology of so-called Occult Phenomena*
- 1902-1903 – attends lectures of Janet in Paris for 4 months, on the impact of emotions on the ‘mental level’ (*l’abaissement du niveau mental*)
- 1903-1904 – returns to Burghölzli, begins developing word association test with Franz Riklin
- 1904-1906 – important publications on word association test, development of concept of *emotionally-charged complex*
- 1907 – publishes *On the Psychology of Dementia Praecox*, referencing Janet more than Freud
The crucial years: 1907-1908
Jung, Freud, Bleuler and Janet

- Bleuler read and reviewed Janet’s works, and directly linked Janet’s *Psychasthenia* to his *Schizophrenia*
  - Bleuler did not, however, correspond with Janet or meet him
- Jung and Freud began their intense relationship in 1906, meeting in 1907
- A *Society for Freudian Research* formed in Zürich in 1907, with Bleuler as the head
  - Jung and Bleuler struggle to apply Freud’s ideas on *infantile sexuality* to schizophrenia
- Jung’s allegiances torn between Freud and Janet
Jung announces to Freud that he plans to visit Janet in June 1907, to discuss Freud’s ideas and the concept of schizophrenia with him.

‘I wish you an interesting Paris complex, but I should not like to see it repress your Vienna complex’ (14 June).

‘I was very glad to hear that you are back at work at Burghölzli and am delighted with your impressions of your trip. You can imagine that I would have been very sorry if your Vienna complex had been obliged to share the available cathexis with a Paris complex. Luckily, as you tell me, nothing of the sort happened, you gained the impression that the days of the great Charcot are past and that the new life of psychiatry is with us, between Zürich and Vienna. So we have emerged safe and sound from a first danger’ (1 July).
First uses of ‘schizophrenia’ (literally, ‘split mind’): April, 1908

- ‘Kraepelin’s dementia praecox is not necessarily either a form of dementia or a disorder of early onset. For this reason… I am taking the liberty of using the word schizophrenia to denote Kraepelin’s concept. I believe that the tearing apart (“Zerreissung”) or splitting (“Spaltung”) of psychic functions is a prominent symptom of the whole group and I will give my reasons for this elsewhere.’

  (Bleuler at German Psychiatry Conference, Berlin)

- ‘We have borrowed from French psychology a similar concept which initially was true for hysteria – namely, “dissociation.” Today, the name means a “splitting of the self” . . . Hysteria is primarily characterized by dissociation and because dementia praecox also shows splitting (“Spaltung”), the concept of dissociation seems to blend into the concept of Schizophrenia.’

  (Jung at the First International Congress of Psycho-analysis, Salzburg)
‘I call dementia praecox “schizophrenia” because… the “splitting” of the different psychic functions is one of its most important characteristics... In every case we are confronted with a more or less clear-cut splitting of the psychic functions. If the disease is marked, the personality loses its unity; at different times different psychic complexes seem to represent the personality... one set of complexes dominates the personality for a time, while other groups of ideas or drives are “split off” and seem either partly or completely impotent’ (pp. 8-9).

Clearly, this sounds like ‘dissociation’. But we must ask: ‘What is meant by splitting and what is meant by complexes?’
Splitting (‘Spaltung’) 

- Prior to 1911, Bleuler extensively used the term ‘dissociation’. From *Consciousness and Associations* (1905):
  - ‘(D)issociation of the personality is fundamentally nothing else than the splitting off of the unconscious…”
- From the 1911 book:
  - ‘It is the splitting which gives the peculiar stamp to the entire symptomatology’ (p. 362).
  - ‘What Gross understands by his term “fragmentation”… of consciousness corresponds to what we call “splitting”. The consciousness, however, cannot fragment itself, but only its contents… The term ‘dissociation’ has already been in use for a long time to designate similar observations and findings. But dissociation also designates more: for example, the constriction of the content of consciousness… [and] may thus give rise to misunderstandings’ (p. 363).
  - ‘The affectively charged complex of ideas continues to become isolated and obtains an ever increasing independence (splitting of the psychic functions)” (p. 359).
Complexes, according to Jung

- Concept of *complexes* developed out of word association task
  - Latencies, strange associations, disruptions of attention, forgetting of prior responses
  - Complexes are described as clusters of ideas ‘cemented’ together by a powerful affect (p. 28), and accompanied by ‘somatic innervations’ (p. 41). Jung described a complex as a ‘being, living its own life and hindering and disturbing the development of the ego-complex’ (p. 47).
- In Jung’s later writings:
  - ‘Especially in those states where the complex temporarily replaces the ego, we see that a strong complex possesses all the characteristics of a separate personality. We are, therefore, justified in regarding a complex as somewhat like a small secondary mind…’ (Jung, 1911).
  - ‘Today, we can take it as moderately certain that complexes are in fact “splinter psyches.” The aetiology of their origin is frequently a so-called trauma, an emotional shock or some such thing, that splits off a bit of the psyche’ (Jung, 1934/1960, pp. 97-98).
Complexes, according to Bleuler

- From ‘Consciousness and associations’ (1905):
  - ‘Independently of the conscious personality, wishes and fears regulate ideas to their liking and combine them in a compact complex, whose expressions emerge as “hallucinations”; these appear to be so… deliberate that they simulate a third person… But it is merely a piece of the split-off personality…’ (p. 279)
  - ‘There is… no difference in principle between unconscious complexes and these several personalities endowed with consciousness. When an unconscious complex associates to itself an increasing number of the elements of the ordinary ego, without linking itself with the ego as a whole, it becomes finally a second personality.’ (p. 291).

- From Dementia Praecox (1911):
  - ‘Complex’ is ‘a shortened term for a complex of ideas which are strongly affectively charged… (and) strives to obtain a kind of independence’ (p. 24)
  - ‘The complex which has here become unconscious behaves as a dissociative piece of the mind, gathering experiences and making use of them’ (p. 284).
Bleuler’s schizophrenia and dissociation

- Delusions and hallucinations were not, according to Bleuler, core symptoms of schizophrenia.

- ‘Loosening’ of associations (similar to Janet’s *reduction in psychological tension*) was important.
  - *Splitting* is essentially *dissociation*.
  - *Complexes* come very close to Janet’s *fixed ideas*, or the *emotional parts of the personality* in the theory of *structural dissociation*.

- Bleuler’s schizophrenia bears many similarities to dissociation and dissociative disorders.

- Clearly, some cases described by Bleuler would today be called *DID*, but this does not explain why his *theoretical* explanations for schizophrenia link so closely to Janet’s ideas.
Enigma 2: Kurt Schneider and the 1st rank symptoms of schizophrenia

- German psychiatrist in the tradition of Emil Kraepelin and Karl Jaspers
  - After Kraepelin, was committed to schizophrenia as a brain disease (of unknown etiology)
  - Following Jaspers, emphasized phenomenology and the ‘form’, not ‘content’, of symptoms
Genesis of the 1st rank symptoms

- In 1939, Schneider first proposed ‘1st rank’ symptoms for schizophrenia in a book for general physicians
  - As the most effective means of distinguishing schizophrenia from affective psychosis
  - These ideas were based on the examination of 5000 patients, known as the Schwabing cohort
- In 1950, they were incorporated into his book, *Clinical Psychopathology*
  - Translated into English in 1959
- First rank symptoms were specific to schizophrenia
  - ‘When we say, for example, that thought withdrawal is a first rank symptom, we mean the following. If this symptom is present in a non-organic psychosis, then we call that psychosis *schizophrenia*, as opposed to *cyclothymic* psychosis, or *reactive* psychosis’ (Schneider, 1959)
Impact on psychiatric diagnosis

- 1st rank symptoms incorporated into Wing’s *Present State Examination*, in 1967
  - Then into the Research Diagnostic Criteria in 1978
    - because of evidence they could be ‘reliably’ assessed
    - and because ‘delusions’ and ‘hallucinations’ were considered not specific enough

- Highly emphasized in DSM-III, III-R and IV, and in ICD-9 and 10 diagnostic criteria for schizophrenia
  - Only one 1st rank symptom required for a schizophrenia diagnosis
    - Eliminated from DSM-5 due to lack of evidence for diagnostic specificity(!)
    - Included, but de-emphasized (1 of 4 necessary symptoms), in proposed ICD-11 schizophrenia criteria
What are the 1st rank symptoms?

- Schneider’s description of symptoms from *General Psychopathology* (1959):
  - ‘Audible thoughts; voices heard arguing; voices heard commenting on one’s actions; the experience of influences playing on the body (somatic passivity experiences); thought-withdrawal and other interferences with thought; diffusion of thought; delusional perception and all feelings, impulses (drives), and volitional acts that are experienced by the patient as the work or influence of others. When any of these modes of experience is undeniably present, and no basic somatic illness can be found, we may make the decisive clinical diagnosis of schizophrenia’ (pp. 133-134)
1st rank symptoms as described by Mellor (1970)

1. Auditory experiences
   1. Hearing one’s own thoughts aloud
   2. Two of more voices discussing or arguing
   3. Voices commenting (in 3rd person) one one’s actions

2. Passivity experiences
   1. Imposed bodily sensations (somatic passivity)
   2. ‘made’ feelings - attributed to an external source
   3. ‘made’ impulses/drives - from an outside force
   4. ‘made’ actions - behavior controlled by an outside force (patient feels like an ‘automaton’)

3. Disturbances of thinking
   1. Thoughts withdrawn from mind by an external source
   2. Thoughts inserted into mind by an external source
   3. Thought diffusion or broadcasting

4. Delusional perception - a normally-experienced perception, followed by a delusional interpretation (delusions of reference)
Kluft’s (1987) 1st rank symptoms as a diagnostic clue to MPD

- Richard Kluft, a dissociative disorders (and hypnosis) expert, begin noticing 1st rank symptoms in his MPD(DID) patients after Mellor’s (1970) paper
- For about 10 years, he systematically assessed these symptoms in his MPD patients
  - Only included those who had been integrated/fused to reduce possible ‘misdiagnosis’
Prevalence of 1st rank symptoms in MPD/DID

1. **Auditory experiences**
   1. Hearing one’s own thoughts aloud 0%
   2. Two of more voices discussing or arguing 33%
   3. Voices commenting (in 3rd person) one one’s actions 30%

2. **Passivity experiences**
   1. Imposed bodily sensations (somatic passivity) 37%
   2. ‘made’ feelings - attributed to an external source 77%
   3. ‘made’ impulses/drives - from an outside force 47%
   4. ‘made’ actions - behavior controlled by an outside force 47%
      (patient feels like an ‘automaton’)

3. **Disturbances of thinking**
   1. Thoughts withdrawn from mind by an external source 47%
   2. Thoughts inserted into mind by an external source 43%
   3. Thought diffusion or broadcasting 0%

4. **Delusional perception** - a normally-experienced perception, followed by a delusional interpretation (delusions of reference) 0%
1st rank symptoms in DID and schizophrenia

- Others (e.g., Colin Ross et al., 1989, 1990; Dorahy et al., 2009) replicated Kluft’s findings
  - 1st rank symptoms as or more common in DID than in schizophrenia
  - Dorahy (2009) found *voices commenting* 2x more common, and *voices conversing* 5x more common in DID than in schizophrenia

- In schizophrenia, 1st rank symptoms are consistently *not* associated with poor outcome. Some evidence for the opposite:
  - *positive* outcome in 1st episode schizophrenia over 2 years (significantly shorter hospitalizations, Thorup et al., 2007)
  - shorter duration of illness \( (r = -0.29) \) and fewer hospitalizations \( (r = -0.40) \) in a more chronic schizophrenia sample
Enigma 2: What was Schneider thinking?

- We don’t know!
  - Limited information on the Schwabing cohort (what kind of patients?)
  - Schneider also worked as a military psychiatrist and with prostitutes

- 1st rank symptoms highly consistent with DSM-IV Dissociative Disorder Not Otherwise Specified diagnosis (DDNOS, and the proposed ICD-11 Complex Dissociative Intrusion Disorder)
  - One primary part of the personality
  - Persistently intruded into by other parts of the personality

- Intrusions and withdrawals between parts of the personality can explain the 1st rank symptoms common in DID/DDNOS (voice hearing; ‘made’ feelings, actions, impulses; and thoughts withdrawn or inserted)
  - ‘Indeed, it is a clinical commonplace for personalities to state that they have made another see or hear something, influenced another’s perceptions, caused a sensation, impulse, or action in some other alter, or taken away the alter’s memory’ (Kluft, 1987, pp. 297-298)

- But not thought broadcasting or delusional perception (genuine delusions), which appear to be very rare in dissociative disorders (and BPD)
Enigma 3: The double bind theory of schizophrenia and disorganized attachment

- Gregory Bateson (1904-1980)
- Trained as an anthropologist
- Conducted fieldwork (with Margaret Mead) in New Guinea and Bali
- Interested in mother/child communication and the construction of ‘play’
- Developed concepts of feedback loops and self-regulating systems, within field of cybernetics
- Applied to the etiology of schizophrenia
Toward a theory of schizophrenia (1956): Bateson, Jackson, Haley and Weakland

- Argued for a regular pattern of disturbed communication between mother and child, from infancy on, that leads to later disturbed ‘schizophrenic’ thinking and behavior
  - ‘We must look not for some specific traumatic experience in the infantile etiology but rather for characteristic sequential patterns’ (p. 209)

- Analyzed written and verbal reports, along with recordings, of therapy with schizophrenic patients, and with patients and their parents, and recorded interviews with the parents
What is the double bind?

Repeated interactions in a close relationship involving:

1. A threat of punishment (‘either the withdrawal of love or the expression of hate or anger – or most devastating – the kind of abandonment that results from the parent’s expression of extreme helplessness’, p. 210)

2. A secondary ‘injunction’, usually expressed non-verbally, contradicting the first

3. A third ‘injunction’ prohibiting escape from the relationship (‘it is perhaps unnecessary to list this as a separate item since... the other two levels involve a threat to survival, and if... imposed during infancy, escape is naturally impossible’ (p. 211)

4. Once the ‘double bind’ pattern is established over time, only one part of a sequence may be necessary to ‘precipitate panic or rage’
A simple example of a ‘double bind’ exchange observed

‘A young man who had fairly well recovered from an acute schizophrenic episode was visited in the hospital by his mother. He was glad to see her [it is assumed] and impulsively put his arm around her shoulders, whereupon she stiffened. He withdrew his arm and she asked, ‘Don’t you love me any more?’ He then blushed, and she said, ‘Dear, you must not be so easily embarrassed and afraid of your feelings’. The patient was able to stay with her only a few minutes more and following her departure he assaulted an aide…’ (p. 222)
What drives the double bind?

- They hypothesize that the family of a person who becomes schizophrenic has the following characteristics:
  - The mother becomes anxious and hostile when approached by the child (‘in danger of intimate contact’)
  - However, such feelings are not acceptable, and – if the child responds to the rejection – are denied by expressing loving behavior ‘to persuade the child to respond to her as a loving mother’
  - ‘To put this another way, if the mother begins to feel affectionate and close to her child, she begins to feel endangered and must withdraw from him; but she cannot accept this hostile act and to deny it must simulate affection and closeness with her child’ (p. 219)
  - The child is punished (in some way) regardless of the response he makes, and cannot recognize the contradiction
  - To survive he must ‘falsely discriminate his own internal messages as well as falsely discriminate the messages of others’ (p. 220)

- Consistent with ‘mentalization’ problems in schizophrenia (and other disorders), where the child learns to try not to recognize/think about the intentions of his caretaker (or their own mental states; Fonagy et al, 2003).
The fate of the *double bind* theory

- Fell out of favor, particularly with the ascent of the biomedical paradigm and antipsychotic medications
  - Accused, along with Fromm-Reichmann’s ‘schizophrenogenic mother’, of ‘blaming the family’, which proved politically unacceptable
  - Research supporting it was weak – no longitudinal studies

- But tradition continued in more subtle forms as ‘expressed emotion’ (EE) research (low warmth, overinvolvement, high expressed hostility)
  - Which predicts relapse in psychotic disorders
Disorganized attachment (DA)

- Pattern of attachment in young infants first recognized by Mary Main in late 1980s
  - Videos of ‘Strange Situation’ experimental task with parents and infants generated three patterns of attachment: secure, insecure anxious/ambivalent and insecure avoidant
  - But many videos could not be classified into these 3 categories
  - Careful review of over 200 videos provided evidence of contradictory patterns in the infant – apparent desires to approach and flee simultaneously
Main and Hesse (1990) argued that DA behaviors occur because the parent is a source of fear for the infant, as well as being the only possible source for comfort.

- ‘fright without solution’

The caretaker exhibits frightened or frightening behaviors or facial expressions, which disturb the infant.

- Why? Because of ‘unresolved’ trauma or loss experiences (as demonstrated on the Adult Attachment Interview (AAI)), triggered in their interactions with their infant.

- Many of these parents are presumed to have had DA experiences in early childhood and may thus find close relationships frightening.

- Parental behavior does not have to be overtly abusive.

Infant is in an approach/avoidant conflict, which induces bizarre behavior (i.e., crawling backward toward parent, avoiding eye contact).

- Phenotypic similarity to Bateson’s double bind, as verbal behavior may contradict non-verbal behavior (i.e., facial expressions).

- Argued by Liotti, 1992 to predict subsequent dissociation, which research has supported.
Disorganized attachment and *internal working models*

- ‘The child experiences rapid shifts in which the caregiver is at first frightened [or *frightening* or *dissociative*], then no longer frightened, then caring for the child. With each shift, a different model of self (perpetrator of fright, rescuer, loved child) and of the caregiver (victim, rescued victim, competent caregiver) is operative. These multiple models of the self and other cannot be integrated by young children and are retained as multiple models’ (from Attachment and Psychopathology, the *Attachment Handbook*, p. 729)

- Sometimes known as the ‘drama triangle’ (or mistakenly, the *trauma* triangle).
Summary and conclusions

- The historical concept of schizophrenia connects with dissociation in at least 3 ways:
  - Bleuler’s original concept of schizophrenia is infused with dissociative concepts
  - Schneider’s 1st rank symptoms of schizophrenia are easily explained from a dissociation perspective
    - most are more common in DID than in schizophrenia
  - Bateson’s double bind theory of schizophrenia …. 
Explanations?

- What does this all mean?
  - The ‘group’ of schizophrenias includes a highly dissociative subgroup, which explains the numerous links - dissociative psychosis?
  - ‘Schizophrenia’ itself is a form of dissociative disorder - DDNOS or Complex Dissociative Intrusion Disorder?
    - Psychotic symptoms – *Trauma identity states*, or *emotional* parts of the personality?
    - Negative symptoms - poorly functioning *neutral* identity states or *apparently normal* parts of the personality?

- Psychotic symptoms may ‘allow’ the expression of powerful emotions
  - Is psychosis a cure for the double bind?
How to solve the enigmas

- Careful longitudinal research, from before birth to adulthood
- Screening all schizophrenia/psychotic disorder samples for posttraumatic and dissociative disorders
- Developing more valid diagnostic criteria for schizophrenia or the ‘core’ psychotic disorders
Eugen Bleuler ‘final words’ (1911)

- Unlike Jung, Bleuler generally thought of schizophrenia as an organically-based brain disease
  - But sometimes he too wondered
- ‘The stronger the affects, the less pronounced the dissociative tendencies need to be in order to produce the emotional desolation. Thus, in many cases of severe disease, we find that only quite ordinary everyday conflicts of life have caused the marked mental impairment; but in milder cases, the acute episodes may have been released by powerful affects. And not infrequently, after a careful analysis, we had to pose the question whether we are not merely dealing with the effect of a particularly powerful psychological trauma on a very sensitive person rather than with a disease in the narrow sense of the word’ (p. 300)